TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding RX

Respondent Name
Federated Mutual Insurance Co

MFDR Tracking Number
M4-16-1427-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This medication does not fall into any of the categories regarding preauthorization. This drug does not require preauthorization. This drug does not require preauthorization and is to be retrospectively reviewed."

Amount in Dispute: $988.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor has submitted no scientific or clinical documentation regarding the efficacy of the treatment to provide evidence that this compound is broadly accepted as the prevailing standard of care. This further supports the carrier's contention that the manner in which this compound medication was to be used is experimental / investigational. As preauthorization was neither sought nor obtained, the carrier is not liable for the billed services."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Service	Amount In Dispute	Amount Due
August 31, 2015	Pharmacy services	$988.11	$988.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services not

subject to a certified network.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification / authorization / notification absent
   - 930 – Pre-authorization required, reimbursement denied
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 351 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Is the carrier's preauthorization denial supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service with claim adjustment reason code, 930 - "Pre-authorization required, reimbursement denied." 28 Texas Administrative Code §134.503 (b)(1) states in pertinent part,

   > Preauthorization is only required for:
   >
   > > (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
   > >
   > > (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
   > >
   > > (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The service in dispute is a compound medication containing Meloxicam, Flurbiprofen, Tramadol, Cyclobenzaprine, Bupivicaine, Baclofen, Amantadine, Gabapentin, Amitriptyline, Bupivicaine, therefore §134.503 (b)(1)(B) applies.

   Review of Appendix A of the ODG Workers' Compensation Drug Formulary finds that:
   - none of the drugs contained in the compound in dispute are listed as a "N" drug; and
   - while Bupivicaine HCL is not found on the Appendix A, Drug Formulary, it is also not found to be investigational or experimental based on search of the Food and Drug Administration web site at, http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm

   The division concludes that preauthorization was not required for service in dispute. For that reason, the division finds that the carrier's preauthorization denial is not supported.

2. 28 Texas Administrative Code §134.503(c) states

   > The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   >
   > > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   > >
   > > > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   > > >
   > > > (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   > > >
   > > > (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Quantity	Amount Billed	MAR ((AWP per unit) x (number of units) x 1.25)
August 31, 2015	Meloxicam Bulk Powder	1	$35.04	$194.67000 x 1 x 1.25 + $4.00 = $247.34
August 31, 2015	Flurbiprofen Powder	5	$168.72	$36.58000 x 5 x 1.25 + $4.00 = $232.63
August 31, 2015	Tramadol HCL Bulk Powder	6	$168.00	$36.30000 x 6 x 1.25 + $4.00 = $275.25
August 31, 2015	Cyclobenzaprine HCl Bulk Powder	2	$80.37	$46.33200 x 2 x 1.25 + $4.00 = $119.83
August 31, 2015	Bupivacaine Powder	1	$46.02	$45.60000 x 1 x 1.25 + $4.00 = $61.00
August 31, 2015	Baclofen Powder	5	$184.68	$35.63000 x 5 x 1.25 + $4.00 = $226.69
August 31, 2015	Amantadine HCL	3	$38.46	$24.22500 x 3 x 1.25 + $4.00 = $94.84
August 31, 2015	Gabapentin Powder	4	$188.10	$59.85000 x 4 x 1.25 + $4.00 = $303.25
August 31, 2015	Amitriptyline Bulk Powder	2	$30.70	$18.24000 x 2 x 1.25 + $4.00 = $49.60
August 31, 2015	Bupivicaine Powder	1	$48.02	$45.60000 x 1 x 1.25 + $4.00 = $61.00
		Total	$988.11	$1,671.43

The maximum allowable for the service in dispute is $1,671.43 based on the reported NDC number and units. The requestor is seeking $988.11. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $988.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $988.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.